Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
WOON K. SIM, MD

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-13-3130-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 25, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim is still being reduced in error. This claim was for a Division ordered Designated Doctor Re-Exam. We billed a total of $1,275.00 for this claim but were paid only $191.65. The explanation given on the EOB justifying the denial states: WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT; CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION; however, this is incorrect. The reduction of parts of this claim is in violation of the rules of the Texas Department of Insurance Division of Workers' Compensation as this service was ordered on the DWC-32."

Amount in Dispute: $308.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Gallagher Bassett escalated the claim in question for date of service 12.04/12 for further review by the bill audit company."

Response Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 4, 2012	CPT Code 99456-W6-RE Designated Doctor Examination for Extent of Injury	$308.35	$308.35
	CPT Code 95851 Range of Motion Testing	$0.00	$0.00
TOTAL		$308.35	$308.35

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 16-Claim/Service lacks information which is needed for adjudication.
- W1-Workers compensation state fee schedule adjustment.

Issues

Is the requestor entitled to additional reimbursement?

Findings

On the disputed date of service the requestor billed CPT codes 99456-RE-W6 and 95851. CPT code 95851 is not in dispute.

- 28 Texas Administrative Code §134.204(i)(1)(C) states "The following shall apply to Designated Doctor Examinations. (1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows: (C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier 'W6'."
- 28 Texas Administrative Code §134.204(n)(21) defines the "W6" modifier as "Designated Doctor Examination for Extent--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining extent of the employee's compensable injury."

A review of the submitted medical billing finds that the requestor billed modifier "W6" for the extent of injury examination. The Division concludes that the requestor billed for the testing in accordance with 28 Texas Administrative Code §134.204.

The maximum allowable reimbursement (MAR) for CPT codes 99456-RE-W6 is:

- 28 Texas Administrative Code §134.204(k) states "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

- 28 Texas Administrative Code §134.204(i)(2) states "When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection: (A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section; (B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section."

Because only one examination was performed concurrently under paragraph (1)(C) - (F), reimbursement at 100 percent of the set fee outlined in subsection (k) is recommended; therefore, reimbursement of $500.00 is recommended. The respondent paid $162.50. The difference between the total allowable and paid is $337.50. The requestor is seeking $308.35 As a result, the requestor is entitled to reimbursement of $308.35.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $308.35.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $308.35 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		11/21/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.